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ABSTRACT

Hospitalized latency age children must confront their feelings surrounding illness, treatment, and hospitalization; and care must be taken so that normal developmental stages are minimally disrupted. Roadblocks to psychosocial growth may occur in the development of mastery, body image, cognitive understanding and family relationships. Often the child cannot actively master his or her world because of physical restrictions imposed during illness. The development of a positive body image is often upset because of activation of negative fantasies. The latency period appears to be a critical time for children to cognitively understand their illnesses and the intervention of the medical staff during hospitalization. The relation between the child and family also appears to follow a particular developmental sequence. Some potential benefits of hospitalization are discussed. There are several concrete guidelines suggested which can be applied to aid the developmental processes of the hospitalized latency age child. (Author/RH)

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Psychosocial Aspects of Latency Age Children

Symposium: The Child in the Hospital

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Abstract

The hospitalized latency age child is often forced to deal with emotional feelings surrounding his illness or hospitalization which can be psychologically damaging. Common roadblocks to psychological growth for the latency age child occurs in the development of mastery, body image, cognitive understanding and family relationships. The latency age child must master not only his feelings surrounding the illness and hospitalization, but care must be taken so that normal developmental tasks are not disrupted. Often the child cannot actively master his world because of physical restrictions imposed during his illness. The development of a positive body image is often upset because of activation of negative fantasies. The latency period appears to be a critical time for the child to cognitively understand his illness and the intervention of the medical staff during hospitalization. The interaction between the child and his family also appears to follow a particular developmental sequence. Some potential benefits of hospitalization are discussed. Finally, concrete guidelines are enumerated which are directed specifically toward the developmental issues of the latency age child.

Psychosocial Aspects of Latency Age Children

As pediatric care has become more concerned with the children's psychosocial and emotional development (Chess, 1966), the psychological impact of hospitalization on the child has been studied. It has been shown that hospitalization can upset the delicate interfacing of psychological and biological processes which contribute to the development of personality (Nagera, 1978). Unlike the adult, the child lacks the necessary ego resources to maintain emotional or behavioral control when confronted with overwhelming fear, anxiety, and pain. He often responds with maladaptive or damaging coping styles which are his only defense against his fears.

Regardless of age, hospitalized children have realistic fears centering around their prognosis, pain of the illness, and pain of the treatment. In addition, all the children have accompanying unconscious fears which involves the children's private fantasy life of being punished, attacked, or mutilated. When the age factor has been taken into account, it has been hypothesized that a curvilinear relationship exists between age and the degree of psychosocial upset after a hospitalization, with preschool-age children and adolescents being at the greatest risk for increased upset (Vernon, Foley, Sipowitz, et.al., 1965).

Although latency age children do not appear to have the profound separation reactions to hospitalization as do preschool-age children, or the turbulent outburst reactions of the adolescent, it is still a time of intense psychological adaptation and anxiety that cannot be ignored (Prugh, Staub, Sands, Kirshbaum & Lenihan, 1953). The purpose of this

paper is to explore some of the common roadblocks to psychosocial growth in hospitalized latency age children as they impinge upon the development of mastery, body image, cognitive understanding, and family relationships. Potential benefits of hospitalization as well as some guidelines for the care of the children of latency age will be enumerated.

Mastery: Tasks During Health and Illness

The latency age child must deal with two types of mastery during his hospitalization: (1) the mastery of and coping with the illness and the hospitalization experience, and (2) the normal developmental mastery of his world as characterized by the latency age conflict of industry versus inferiority (Erikson, 1963). The younger child does not have this kind of mastery concern. For example, Blom (1958) showed that latency age children (7-13 years) were most anxious about narcosis, which appeared to represent a threat to self-control and mastery, while the younger children were most anxious about maternal separation.

The non-hospitalized latency age child normally controls his outside world and his unconscious inner impulses through "action." The latency age child is normally active motorically--constantly expressing his positive and negative emotions physically. In contrast, the hospitalized child has been thrust into a situation where he cannot actively express or master the normal life tasks through his usual channels. He must deal with a mastery of the overwhelming feelings of his illness and the reality-based possibility of pain, suffering, or even death in an atmosphere that is severely limiting to his motoric expressions. In addition, the child must master the entire hospitalization

experience which sometimes can be more traumatic and distressing than the illness itself. While hospitalized, the child can no longer care for himself and feels that he cannot control his destiny. He has become immobilized. The previously learned independent skills such as eating, elimination, and dressing now must give way to nursing care, either because of the illness itself or because of hospital procedures. In addition, all previously enjoyed patterns of mastery including school and peer group contacts have been disrupted. Thus, the illness and hospitalization together can sometimes place the latency age child in the position where "action" is impossible; mastery cannot take place either for normal developmental industry tasks or for the overwhelming emotions surrounding the hospitalization and illness.

Anna Freud (1952) says that a child reacts to illness and hospitalization either by withdrawing from the object world and focusing all libidinal energy on the needs of his body, or by reaching out and demanding an overabundance of love and attention from his mother. Those responses may show themselves on the pediatric ward with counterphobic defenses such as denial of serious illness and discharge of negative motion such as excessive demands on the nursing staff. Most commonly, the inability to master his environment, along with his fostered hospital dependency, leads to infantile regression which is a major threat to the child's ego and self-image. A more socially accepted coping style for nursing and medical staff is to involve the latency age hospitalized child in trying to form relationships on the ward with peers for the purpose of strengthening his faultering ego. Through this period of stressful hospitalization,

the latency age child needs to develop a peer support system for himself.

Mastery of his illness as well as mastering the life task before him during latency can be facilitated during the child's hospitalization through the "action" of play. Many hospitals have child-life programs whose purpose it is to reduce the deleterious effects to the child's illness and the medical treatment through play, but Becker (1975) has warned that play programs which are dished out "cafeteria-style" without thought to the child's peculiar cognitive understanding of the symbolism and meaning of the play can be very damaging. This play may force a child to confront emotional issues the child is not ready to handle. Care must be taken that the play is meeting the needs of the child on his current level of mastery and understanding with the goal of helping him discover a more thorough understanding of his hospitalization and illness. Mastery is a central issue in the emotional well-being of the hospitalized latency age child and unless care is taken in its facilitation and development, damaging effects could ensue.

Body Image: The Foundation of Self-Esteem

Although the older latency age child has some concerns regarding his changing body prior to adolescence, little awareness or concern over bodily matters are seen during the normal latency age period (Gellert, Gircus, & Cohen, 1971). On the other hand, when the child is ill and hospitalized, concerns and anxieties centering around the body and its functions are sensitized and heightened. The latency age child no longer is in control of his body which prior to this time has been

his major tool for mastering his world. The latency age child has given up his body to the medical staff; he has little control or mastery over its movements or functions. The hospitalized child is often confronted with novel intrusions to his body through numerous medical probings. Even the process of the physical examination can precipitate feelings of resentment and anxiety for the latency age child because of previously acquired feelings of modesty and shame concerning nakedness (Nagera, 1978). This process is clearly evident in most teaching hospitals when the children react with a paralyzing compliance as they are compelled to display their bodies with their defects to a hoard of doctors, nurses, residents, and medical students.

The most damaging aspect of this focus of attention on the body is not the attention itself, but the accompanying activation of fantasies to the latency age child of being punished, attacked, disfigured, and mutilated (Prugh et.al., 1953). The latency age child does not yet have the cognitive understanding of the illness or the mastery of the surroundings which might aid him in coping with these fantasies. Since most of the latency age child's energies are focused on the illness within his body and he has less time available for any other psychic demands, his fantasies and fears are magnified. The latency age child's ego has been rendered impotent to adaptively cope with his private fantasies and the distorted view of his reality. These distortions of his illness, which are modulated by his level of cognitive understanding, ethnic background, and family constellation (Williams, 1978), can greatly affect the development of his self-image.

Cognitive Understanding: Mediator of Distortions

The child's body image is greatly affected by his cognitive understanding of his illness and hospitalization. A child prior to 9 years of age has little understanding of his body or how it functions (Erickson, 1965). For example, until about 8 years of age the latency age child imagines his body as a hollow organ cased in skin which is sometimes filled with food and sometimes empty (Fraiberg, 1959). The latency age child has little conception of death (Koocher, 1973) and often interprets the pain surrounding his illness as maltreatment, percecution, and punishment (Freud, 1952). In the same way, the hospitalization with its accompanying enforced separation from his parents is interpreted later by the child as rejection by his parents.

A child's age has been shown to have a positive relationship with the quantity and quality of responses of his concept of illness (Brewster, 1979; Campbell, 1975; Nagy, 1951; Nagy, 1953; Simeonsson, Buckley, and Monson, 1979). Of special interest is how children conceptualize their illness. Campbell (1975) has noted the developmental changes in children's definitions of illness. He asked 264 pediatric patients between the ages of 6 and 12 their definition of their illness. He noted eleven principle content categories pertaining to somatic feeling states, objective detectable indicators, and psychosocial indicators. These latency age children showed a consistent developmental trend in themes dominating their definition of illness. Principle themes varied from non-specific feeling states (feeling sick), to specified somatic feelings (stomach hurts), visible external signs (arm cut), objective signs not clearly visible (hot forehead), and finally to

specific disease concepts (tonsillitis, diabetes). Thus, the definitional sophistication of an illness seems to progress from undifferentiated feeling states to both a more precise definitional concept, as well as a recognition of socialized role performance and psychosocial disposition as significant defining themes. Campbell also noted that the child's definition of his illness was somewhat dependent upon the child's mother's understanding of the illness and the health history of the child. The major consideration, however, was the child's developmental level of cognitive sophistication.

Simeonsson, Buckley, and Monson (1979) studied 60 hospitalized children from 5 to 9 years of age and identified three distinct stages in their conception of their illness shifting from global, undifferentiated concepts to increasingly abstract concepts. In a similar study, Brewster (1979) studied 50 chronically ill, hospitalized children from 5 to 12 years of age and also identified three distinct stages clearly related to the child's level of cognitive development. For the youngest children in the first stage illness is viewed as being the result of some kind of human action. In addition, the child's quality of thought is characterized by magical thought processes and circular logic. For example, a child might respond that he was ill because he "ate someone's sucker" or because he "stole cookies." In the second stage, illness is viewed as being caused by a variety of outside factors related to the illness or physical health. For example, a stage two child might state that his illness was caused by "germs" or by "cutting my finger." Although this stage does not involve the circular, magical thinking as in the first stage, it still only identifies one specific cause for the illness. This second stage lacks an organizing or generalizing principle about the ill-

ness which the child will develop in later years. In the third stage, illness is viewed in terms of a generalized, relative and/or abstract notion in that the phenomena of illness or health was generalized to basic concepts of physical susceptibility or weakness and the basis of treatment. For example, a stage three child might state that his illness was caused by "getting a virus from Danny" or "because my pancreas isn't producing insulin so I can use the sugar in my blood." By the third stage which involves only a small percentage of the 9 year olds (Simeonsson et.al., 1979) but almost all of the 12 year olds (Brewster, 1979), the child is free from egocentric and circular thought processes and appears to have a well-developed understanding of his illness.

Brewster (1979) also studied a similar developmental progression of the hospitalized child's understanding of the medical staff's intentions in regards to the child's medical treatment. The youngest children saw the medical procedures as being done to them in order to inflict punishment. These children would often feel an injection was meant to hurt them for some previous misdeed. By the age of 7 almost all children feel that the staff's empathy depended upon the child expressing pain. For example, the child would often feel that the nurse would be concerned only because he yelled very loudly. Finally, the older latency age child has the ability to infer both intention and empathy from the medical staff. The latency age child's cognitive maturation which progresses by a predictable developmental sequence can greatly affect how he views both his illness and his understanding of his hospitalization. This understanding can greatly affect the quantity and quality of distortions of

the hospital experience which has direct bearing on the child's emotional adjustment and development.

Family Involvement: Dealing With Separation and Guilt

No discussion of the psychosocial aspects of the latency age child's hospitalization can be complete without understanding the dynamic interfacing between the child and his family. Although the pediatric staff often feels that parents can exert little influence during the hospitalization (Gohsman, 1977), it is recognized that the pediatric patients who have adjusted successfully to the hospitalization were those who seemed to have the most satisfying relationship with their parents, especially with their mother (Prugh et.al., 1953).

When a child is extremely ill, families go through a sequence of reactions which begins by a realistic preoccupation with the illness itself. This initial reaction is followed by a phase of negation and incredulity which has been shown to last for long periods of time (Prugh et.al., 1953). It is at this point that the parents go through the "FAGS Syndrome" characterized by fear, anger, guilt, and sadness (Kohlberg & Rothenberg, 1970). During this time, parents blame each other or medical personnel for their child's difficulty which can often result in marital discord. The parents also go through a "grief" reaction when they bring their child into the hospital because they have both physically "lost" their child and because they no longer know exactly what their role should be as parents of a hospitalized child (Brazelton, 1976).

Although the parental reactions are somewhat dependent on the type and severity of the illness and the parents previous coping styles, these

intense emotional reactions from the parents can have a big impact on their hospitalized child. The child's image of his parents changes by seeing his parents obviously helpless, anxious, and unable to alter the traumatic course of events during the hospitalization (Jessner, 1959). Children often become more upset over the emotional reactions of their parents than over the hospitalization or the illness itself.

Parents often unconsciously withdraw from their children emotionally during this period because of the intense negative emotions they experience such as fear, anxiety, and guilt. The child then feels abandoned by his parents and becomes extremely anxious about this apparent parental separation. The latency age hospitalized child has more intense fears related to safety, home, and self-preservation (Astin, 1977) which are exacerbated by the child's perception of his parents' emotional separation from him. The child has neither the energy to deal with the emotional upset of his parents, or the emotional strength to deal with the illness itself. At this point the child feels as though he is very much alone. The result for the child of this dynamic is that he becomes even more withdrawn and depressed.

Benefits of Illness and Hospitalization

Even though an illness and hospitalization for the latency age child can be traumatic and disruptive to normal development, many children benefit emotionally from their hospital stay. As many as 25% of all children hospitalized profit emotionally from the experience in increased coping ability, increased self-awareness, and learning from the personnel in the hospital environment (Vernon et.al., 1965). It has been argued

that preschoolers probably have both the most negative and positive emotional sequellae during hospitalization (Vernon and Schuman, 1964), but latency age children can certainly benefit emotionally if proper care is taken to structure the hospital experience for them to facilitate positive emotional growth (Langsford, 1961).

The experience of the hospital and illness can provide the latency age child with a new set of emotional tasks to master and, if he is successful, it can help promote a positive self-concept. Not only must the child master the reality of the hospital environment with the myriad of new faces, intrusive procedures and emotional disruptions, but he must learn to master and cope with the fantasies which surround his illness and hospitalization that could lead to debilitating anxiety (Blom, 1958; Oremland, 1973). The hospitalization and illness can also provide a child with a "rest" from the anxieties and stresses of home or school, and allow him the luxury of time and energy to integrate his past experiences through a process of reflexion. It has been argued that this type of experience as a child can be useful later in building character as an adult, typified by increased sensitivity, depth of feeling, and widened horizons (Jessner, 1959).

Many latency age children use the hospital time to socialize with hospital staff and peers, which can be a unique and enriching emotional experience for them. Many of the children develop social relationships with staff members which serves the function of helping build ego strength, providing a positive growth experience (Tisza, Hurwitz, and Angoff, 1970). The hospital itself can be thought of as providing a constructive emotional

climate because the child is surrounded by personnel who are attuned to the child's emotional wishes and needs. The hospital staff can also be helpful to parents by modeling the behaviors which can promote constructive interaction with their children (Shore, Geiser, and Wolman, 1965).

Latency age children from troubled and turbulent family backgrounds can use their hospital experience as a much needed way of getting a break from the chaotic, emotionally damaging nature of their home environment. The hospital can be a refuge from the stresses of their troubled world and give them an emotionally corrective and supportive experience. In an inner city hospital, it is quite common to see many latency age children from impoverished backgrounds actually look forward to being hospitalized (Guerin, 1977). While the hospital experience can be traumatic for other children, children from deprived backgrounds can find the hospital a luxurious place with nutritious meals, plenty of adult attention and nurturance, color television and escape from a hassling or abusive parent.

Guidelines for the Care of the Hospitalized Latency Age Child

In the last ten years increased attention has been given to the need for child life activities programs, preparation programs for hospitalization, and parent involvement during hospitalization for all children, as well as a need for competent research in this area (Azarnoff, 1976). Although the importance of these programs and activities is generally recognized, changes in the pediatric establishment with corresponding concrete changes in hospital procedures have been slow in coming (Korsch, 1978). Rothenberg (1978) has suggested that a subtle "conspiracy" exists against children in this country. He attributes many of the resis-

tances of helping professionals to effectively help children has been promoted and is sustained by three unconscious psychological processes including (1) projective reactions where the helper uses the child to project the contents of his own unconscious desires, (2) reversal reactions where the helper uses the child as a substitute for an important figure in the helper's own childhood, and (3) empathic reactions where the helper empathizes with the child's needs and acts to satisfy them. In all cases the helper is responding from his own internal needs and not the needs of the child; the child is being exploited by the so called helping professional. These unconscious mechanisms can restrict the helper's ability to professionally respond to the true needs of the hospitalized child.

Psychology as a profession must take a strong advocacy role for the purpose of promoting the psychosocial and emotional care of children in hospitals. The thrust of our energies should be directed toward helping to facilitate the application of constructive programs and activities which foster emotional development and growth. Organizations such as the Association for the Care of Children in Hospitals (ACCH) have been instrumental in humanizing of health care for children and their families for many years. ACCH has published a policy statement for the care of children and families in health care settings which delineates some general ways pediatric health care settings should respond to children (Association for the Care of Children in Hospitals, 1978). The following is a list of specific recommendations and guidelines for the latency age hospitalized child:

1. In order to promote mastery, the latency age child must be provided with a psychological climate where the developmental tasks of his world can be accomplished with a minimum of disruption. The hospital must not disrupt normal academic functions, peer group interactions, and usual family relationships. It follows that every pediatric ward should include a hospital school program where the latency age child could progress normally in school, liberal opportunities for interaction with friends and other patients, and a flexible allowance for interaction with parents and siblings. In the same way, a child life activities program should be provided in every pediatric hospital to allow the child therapeutic play experiences to help him master fears and anxieties precipitated during the hospitalization. The emotional pulse of each child should be monitored in order that the child's mastery of his hospitalization be facilitated. The mastery experiences provided by the child life program should be individualized to the needs of each latency age patient. Since it has been recognized that latency age children who have had previous histories of poor adjustment are at greater risk for psychological problems during hospitalization, these children should be identified and should be provided with special care.

2. In order to improve the latency age child's body image, care should be taken to reduce feelings of embarrassment and violations of modesty that accompany most hospitalizations. Limits must be placed on the number and type of "zoo trips" on the pediatric ward where the latency age child is compelled to display his body for all to see. The child life activities program is crucial here to help the child understand the purposes of the numerous diagnostic procedures which intrude

on his body. In addition, this program is instrumental in helping the child resolve many of his fantasies of mutilation and annihilation.

3. In order to facilitate cognitive understanding, helping professionals must be attuned and concerned with how each child idiosyncratically perceives his illness and his particular understanding of the hospitalization. The latency age child's adjustment is dependent upon the child being understood from his point of view. Extensive inservice training should be provided to every member of the pediatric staff relating to the developmental progression of how latency age children understand illness as well as the typical distortions most likely to occur. Any child life intervention must be critically evaluated so it is not blindly and insensitively implemented "cafeteria-style" without first taking note of the child's unique emotional state.

4. In order to promote family care of latency age children it must be recognized that parents and extended family can be an invaluable source of information about the child's coping and adaptation to the hospital. Family members should be actively solicited to notify the pediatric staff of any changes in the child's emotional functioning. In addition, the family's emotional support of the latency age child must be encouraged both by official policy and staff attitudes on the pediatric ward.

It is clear that psychologists should play a crucial role in the implementation of these recommendations. The psychologist is often the best qualified member of the pediatric team to review and critically evaluate the utility of the psychosocial intervention programs for hospitalized children. In the same way, psychological consultation must

be provided to the pediatric staff as well as individual patients. An extremely economical and efficient method of providing staff consultation, inservice training and teambuilding is by consultation groups (Rae and Hendelman, 1978). The pediatric staff's unconscious roadblocks to providing high quality emotional care can also be addressed during these groups with a minimum of defensiveness illicited. The active advocacy of these recommendations is crucial if positive mental health is to be promoted in latency age hospitalized children.

References

Association for the Care of Children in Hospitals: statements of policy for the care of children and families in health care settings. Journal of Pediatric Psychology, 1978, 3 (1), 53-54.

Astin, E.W. Self reported fears of hospitalized and non-hospitalized children aged ten to twelve. Maternal Child Nursing Journal, 1977, 6, 17-24.

Azarnoff, P. The care of children in hospitals: an overview. Journal of Pediatric Psychology, 1976, 1 (4), 5-6.

Becker, R. Therapeutic approaches to psychopathological reactions to hospitalization. International Journal of Child Psychotherapy, 1975, 6, 65-97.

Blom, G.E. The reactions of hospitalized children to illness. Pediatrics, 1958, 22, 590-600.

Brazelton, T.B. The emotional needs of children in health care settings. Clinical Proceedings Children's Hospital National Medical Center, 1976, 23 (8), 157-166.

Brewster, A. The relationship of cognitive development to the child's understanding of illness. Unpublished doctoral dissertation. University of Michigan, 1979.

Campbell, J.D. Illness is a point of view: the development of children's concepts of illness. Child Development, 1975, 46, 92-100.

Chess, S. Individuality in children, its importance to the pediatrician. Journal of Pediatrics, 1966, 69 (4), 676-684.

Erickson, F. When 6- to 12-year olds are ill. Nursing Outlook, 1965, 13, 48-50.

Erikson, E.H. Childhood and society (Second ed.). New York: Norton, 1963.

Fraiberg, S.H. The magic years. New York: Charles Scribner's Sons, 1959.

Freud, A. The role of bodily illness in the mental life of children. In E. Eisslen et.al. (Eds.), Psychoanalytic study of the child (Vol. 7). New York: International Press, 1952.

Gellert, E., Gircus, J.S., & Cohen, J. Children's awareness of their bodily appearance: a developmental study of factors associated with the body percept. Genetic Psychology Monographs, 1971, 84, 109-174.

Gohsman, B. Differences in attitudes toward hospitalization between pediatric staff and parents of hospitalized children. Communicating Nursing Research, 1977, 9, 51-58.

Guerin, L.S. Hospitalization as a positive experience for poverty children. Clinical Pediatrics, 1977, 16 (6), 509-513.

Jessner, L. Some observations on children hospitalized during latency. In L. Jessner & E. Pavestedt (Eds.), Dynamic psychopathology in children. New York: Grune & Stratton, 1959.

Kohlberg, I.J. & Rothenberg, M.B. Comprehensive care following multiple life-threatening injuries. American Journal of Diseased Children, 1970, 119 (5), 449-451.

Koocher, G.P. Childhood, death and cognitive development. Developmental Psychology, 1973, 9, 369-375.

Korsch, B.M. Issues in humanizing care for children. American Journal of Public Health, 1978, 68 (9), 831-832.

Nagera, H. Children's reactions to hospitalization and illness. Child Psychiatry and Human Development, 1978, 9 (1), 3-19.

Nagy, M. Children's concepts regarding the origin of illness. Health Education, 1951, 9, 6-12

Nagy, M. The representation of germs by children. Journal of Genetic Psychology, 1953, 83, 227-231.

Oremland, E.K., & Oremland, J.D. (Eds.). The effects of hospitalization on children. Springfield, Ill.: Charles C. Thomas, 1973.

Prugh, D.G., Staub, E.M., Sands, H.H., Kirshbaum, R.M. & Lenihan, E.A. A study of the emotional reactions of children and families to hospitalization and illness. American Journal of Orthopsychiatry, 1953, 23, 70-106.

Rae, W.A., & Hendelman, J.V. Nursing consultation groups: a mental health intervention in pediatrics. Journal of Clinical Child Psychology, 1978, 7 (1), 84-86.

Rothenberg, M.B. Is there a national conspiracy against children in the United States? Proceedings of the 13th Annual Conference of the Association for the Care of Children in Hospitals, 1978, 1, 6-13.

Shore, M.F., Geiser, R.L. and Wolman, H.M. Constructive Uses of a Hospital Experience. Children, 1965, 12 (1), 3-8.

Simeonsson, R.J., Buckley, L. & Monson, L. Conceptions of illness casuality in hospitalized children. Journal of Pediatric Psychology, 1979, 4 (1), 77-84.

Tisza, U.B., Hurwitz, I. & Angoff, K. The use of a play program by hospitalized children. Journal of the American Academy of Child Psychiatry, 1970, 9 (3), 515-531.

Vernon, D.T.A., Foley, J.M., Sipowicz, R.R. et.al. The psychological responses of children to hospitalization and illness. Springfield, Ill.: Charles C. Thomas, 1965.

Vernon, D.T.A., & Schulman, J.L. Hospitalization as a source of psychological benefit to children. Pediatrics, 1964, 34, 694-696.

Williams, P.D. A comparison of Philippine and American children's concepts of body organs and illness in relation to five variables. International Journal of Nursing Studies, 1978, 15, 193-202.